

CONCUSSION "RETURN TO LEARN" / PHYSICIAN RECOMMENDED SCHOOL ACCOMMODATIONS

This patient has been diagnosed with a concussion (brain injury) and is currently under our care. Please excuse from scheduring appointment time. Flexibility and support are needed during recovery. The following are suggested academic adjustme to be individualized for this student, as deemed appropriate in the school setting. Inticipated Symptoms: Sensitivity to: □Light □Sound; Difficulty with: □Sleep □Concentration □Memory □Balance □Irritability □Headache □Dizziness □Visual problems □Nausea □Feeling foggy □Fatigue Area Requested Modifications [check applicable boxes□] Comments Standard Recommendations: No school for 24 hours after concussion; Once student tolerates a 15 minute walk without symptoms, can begin school. Start with half-day school and the progress to full days, as alcerated. □Dismiss student before/after class to avoid crowds Observation Observation School staff to help identify aggravators, to reduce exposure (e.g., bright lights, noisy hallways, attention to school work longer than 20 minutes) □Anticipate breaks during the school day □ Mandatory breaks every: □ □Iff symptoms appear/worsen during class, allow rest in nurse's office; If no improvements after 30 minutes, allow dismissal to home □Water bottle in class / Snack every 3-4 hours Allow sunglasses/Hat □ Larger font for written materials □ Change classroom seating, as needed □ Allow dismissal to home □Water bottle in class of minutes, allow dismissal to home □Water bottle in class of minutes, allow dismissal to home □Water bottle in class of minutes and/or brightness of monitors/screens Auditory Stimuli □ Larger font for written materials □ Change classroom seating, as needed □ Allow class transitions before bell □ Larger font for written materials □ Change class notes or note taker □ Limit time and/or brightness of monitors/screens □ Allow additional time to take test □ Allow additional time to take test □ Allow class transitions before bell □ Changer and the propersion of the service of the propersion of the serv	tudent Name: _	Γ	Date of Birth:	Date of Evaluation	on:
Area Requested Modifications Check applicable boxes Comments	during appoint	nent time. Flexibility and support are i	needed during recov	very. The following are suggested a	
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Clarger font for written materials Change classroom seating, as needed Pre-printed class notes or note taker Limit time and/or brightness of monitors/screens Auditory Stimuli Avoid loud classroom activities, music/band, wood/metal shop, choir, gym Lunch and recess in quiet place (with a friend) wear earplugs, as needed Allow class transitions before bell Simplify tasks and instructions Reduce in-class work Reduce homework (minutes max total, per night) No homework No testing No standardized tests Allow additional time to take test Alternative test methods (oral delivery, oral response, scribe) Maximum one test per day No exertive physical activity until academically back to normal For maximum of 2 weeks; then individualized as per rehab specialist Follow the attached Return to Play protocol: General activity CIF form Sport specific PARENT/GUARDIAN: I give permission for the exchange of information between the school and my child's physical for matters related to school accommodations following a concussion, allowing changes to this plan. Name: Signature: Date: Dat	Breaks	☐ Anticipate breaks during the scho ☐ If symptoms appear/worsen durin improvements after 30 minutes, a	ool day Mandato g class, allow rest allow dismissal to	ory breaks every: in nurse's office; If no	
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School work and Testing		☐ Avoid loud classroom activities,☐ Lunch and recess in quiet place (music/band, wood with a friend)		
Physical Activity General activity until academically back to normal For maximum of 2 weeks; then individualized as per rehab specialist Follow the attached Return to Play protocol: General activity CIF form Sport specific PARENT/GUARDIAN: I give permission for the exchange of information between the school and my child's physic for matters related to school accommodations following a concussion, allowing changes to this plan. Name: Signature: Date: D		☐ Simplify tasks and instructions ☐ Reduce homework (minut ☐ No testing ☐ No standardized to ☐ Alternative test methods (oral del	☐ Reduces max total, per neests ☐ Allow add	e in-class work ght) □No homework ditional time to take test	
PARENT/GUARDIAN: I give permission for the exchange of information between the school and my child's physic for matters related to school accommodations following a concussion, allowing changes to this plan. Name:	•	☐No exertive physical activity unt [For maximum of 2 weeks; then Follow the attached Return to Play	individualized as p protocol:	er rehab specialist]	
his patient will be reassessed here for revision of these recommendations in weeks/days. Please have a sepresentative send me (and parent) periodic updates on functioning in school, until student back to normal.		ARDIAN: I give permission for the	exchange of info	rmation between the school and	my child's physician
presentative send me (and parent) periodic updates on functioning in school, until student back to normal.	Name:	Signat	ıre:	Date:_	
Physician Name (printed or stamp) Physician Address (or stamp) Physician Signature Date	his patient will presentative se	be reassessed here for revision of the and me (and parent) periodic updates of	se recommendatio on functioning in s	ns in weeks/day	s. Please have a scho